Reaching Communities for Child Health and Nutrition

A Proposed Implementation Framework for HH/C IMCI

Workshop Participants

Reaching Communities for Child Health: Advancing PVO/NGO Technical Capacity and Leadership for Household and Community Integrated Management of Childhood Illness ((HH/C IMCI)

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BASICS II

CORE

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Reaching Communities for Child Health and Nutrition

A Proposed Implementation Framework for HH/C IMCI

The Household and Community component of IMCI (Integrated Management of Childhood Illness) was officially launched as an essential component of the IMCI strategy at the First IMCI Global Review and Coordination Meeting in September 1997. Participants recognized that improving the quality of care at health facilities would not by itself be effective in realizing significant reductions in childhood mortality and morbidity because numerous caretakers do not seek care at facilities.

Since that first meeting, several efforts were undertaken to strengthen interagency collaboration for promoting and implementing community approaches to child health and nutrition.

Sixteen Key Family Practices

At the UNICEF-led *International Meeting on Health and Nutrition in Communities* held in Durban, South Africa (20–23 June 2000), participants stressed the need for collaboration among a wide range of partners in the promotion of a core set of practices to improve child health and nutrition at the household and community levels. Meeting participants reached consensus on 16 key family care practices listed in Table 1 (see page 7), which—based on scientific evidence and country experience—contribute to a child's survival and healthy growth. These define the "what" Community IMCI is to target. The key family practices, the backbone of the Community IMCI strategy, are grouped according to four categories of practices that:

- *promote physical growth and mental development*
- *prevent disease*
- *facilitate appropriate home care*
- *facilitate care seeking behaviors.*

Consensus was reached that country experience demonstrates that community and household approaches can be effective in improving these key practices. However, the practices need to be tailored to respond to specific country situations including different levels of health systems performance, emergencies, and HIV/AIDS.

HH/C IMCI Proposed Implementation Framework

Another important workshop, *Reaching Communities for Child Health: Advancing PVO Technical Capacity and Leadership in Household and Community IMCI*, was held in Baltimore, MD (January 17–19, 2001), and organized by CORE and BASICS II with support from USAID/G, USAID/BHR/PVC, and MACRO/CSTS. Participants endorsed an operational framework for HH/C IMCI implementation.

The framework addresses the issue of "how" Community IMCI can be implemented at the community level. This framework enables implementers and their colleagues to communicate better and plan public, private sector, and household interventions that can improve child well-being and reduce child mortality and morbidity in communities,

HH/C IMCI is the optimization of a multi-sectoral platform for child health and nutrition that includes three linked requisite elements:

Element 1: Partnerships between health facilities (and services) and the communities they serve.

Element 2: Appropriate and accessible care and information from community-based providers.

Element 3: Integrated promotion of key family practices critical for child health and nutrition.

within the overall guidelines of the HH/C IMCI strategy established by UNICEF and its partner organizations.

Overview of the HH/C IMCI Implementation Framework

The HH/C IMCI implementation framework distinguishes HH/C IMCI programs from a wider set of community-based programs implemented under a broader definition of Comprehensive Primary Health Care. Each of the elements addresses critical community locales for child caring, illness prevention, illness recognition, home care, appropriate care seeking, and treatment compliance practices.

> ***Element 1*** *focuses on health facilities and outreach clinics, especially in the public sector.*
>
> ***Element 2*** *focuses on private and informal sectors, including volunteers.*
>
> ***Element 3*** *focuses on household and individual practices.*

The multi-sectoral platform, including partnerships with other key ministries (e.g., Nutrition, Agriculture, Water and Sanitation, Local Government) and other key district/community projects and activities (e.g., income generation, civil society organizations), facilitates inclusion to promote adoption of key family practices. It acknowledges the social, political, environmental, and economic foundations upon which families and communities operate. Multiple actors and sectors can help accelerate implementation of HH/C IMCI. Their efforts can help to address factors that facilitate or hinder adoption of new practices and behaviors that are promoted by HH/C IMCI, connect broader development efforts to the key family practices, and promote the active role of local governments and associations in health. This platform is critical for sustainability of HH/C IMCI efforts.

Examples of connections that can be reinforced through the platform include:

> *Improved water and sanitation linked to the promotion of handwashing.*
>
> *Income generation activities linked to the promotion of bednets.*
>
> *Income generation for men linked to men's involvement in reproductive and child health.*

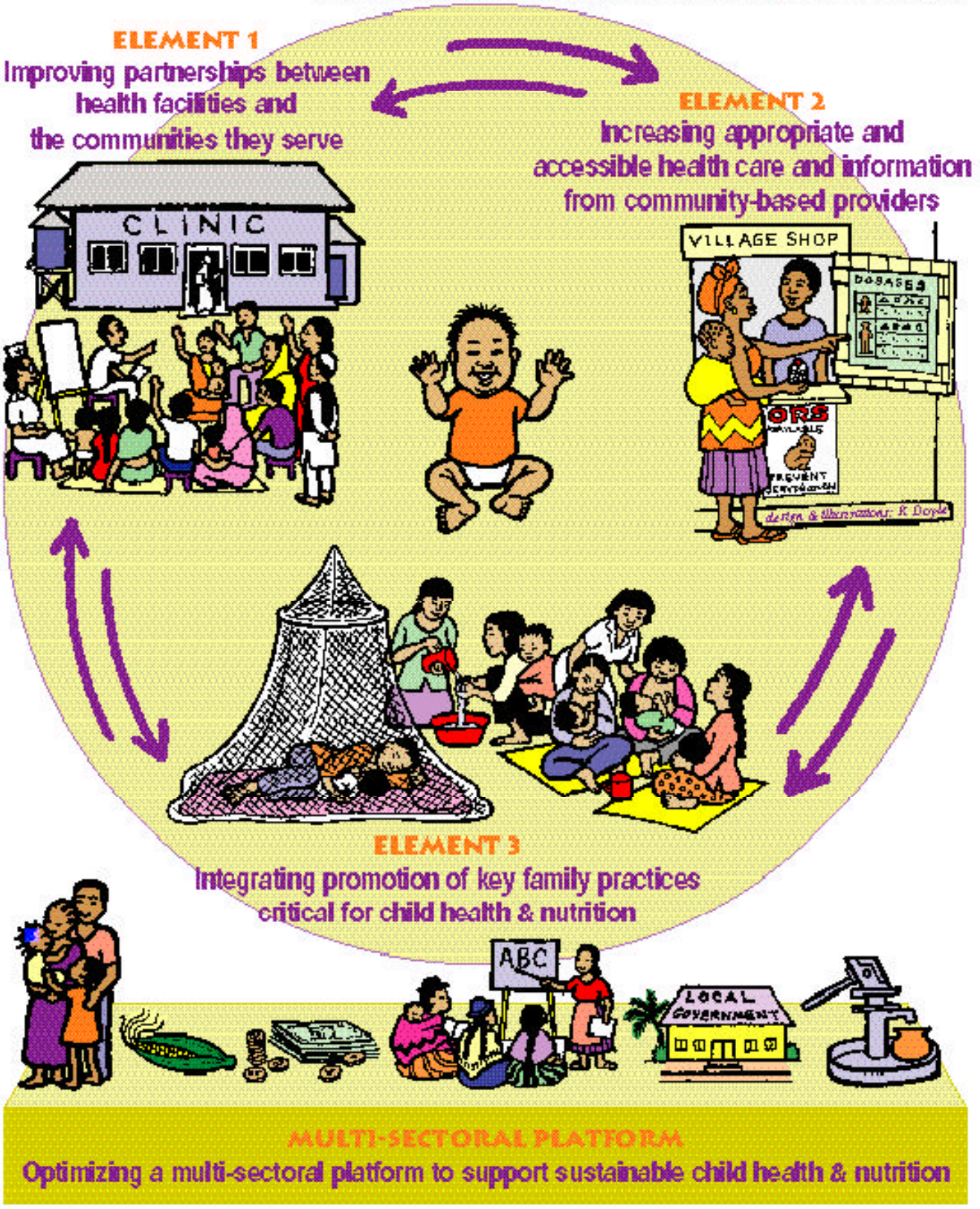
Element 1: Partnerships between health facilities (and systems) and the communities they serve.

Element 1 emphasizes the importance of partnerships (formal or nonformal) between health facilities and communities where both have roles, responsibilities, and accountability to each other.

Several interventions can improve these two-way partnerships:

- *Facility staff can reach out to the community and attract more clients through improved counseling by health workers, increased outreach by health workers, and greater accountability for quality of services.*
- *The community can advocate that caretakers increase usage of facilities where services have been improved, provide community-based data to health facilities to plan appropriate promotional and outreach events, and help manage facilities with government staff.*

HOUSEHOLD & COMMUNITY IMCI
AN IMPLEMENTATION FRAMEWORK



Element 2: Appropriate and accessible care and information from community-based providers.

In many places health facilities are not accessible or are not the first choice in community level care for ill children. Often caretakers seek immediate care from community health workers or other voluntary workers, private providers, traditional healers, traditional birth attendants, shopkeepers and pharmacists—those who enjoy community prestige and are the closest providers of care. In many Private Voluntary Organization (PVO) programs, Community Health Workers (CHWs) are trained to provide basic curative care where other sources of care are not accessible. In all of these circumstances, interventions are needed to:

- *Improve the treatment of sick children (by upgrading the skills of community-based practitioners, and/or using simplified algorithms for case management, and ensuring supply of essential drugs at the community level).*
- *Improve referral of sick children from the community-based providers to the 1st level facility through feedback loops among community-based private providers, facility-based providers, and communities. Communities can help in the establishment of community-based emergency transport systems, community revolving funds, or insurance schemes for health emergencies.*
- *Decrease harmful practices such as frequent use of injections, unsafe treatments, over-prescription of antimicrobials and antibiotics by private providers.*
- *Increase the role of community-based providers in the promotion of preventive practices (e.g., handwashing, condoms).*

Element 3: Integrated promotion of key family practices critical for child health and nutrition.

The third element emphasizes the importance of the key family practices and the need for effective communication and behavioral change packages for their promotion and adoption in the home and in the community. This is often more traditionally recognized as the key strategy for HH/C IMCI. Key interventions include:

- *Using integrated client-centered behavior change strategies based on integrated assessments or surveys. These strategies take into account who is to perform the behaviors, the time (dry season versus wet season, continuous versus periodic, etc.), and the place (household, community, health facility) they are to be performed.*
- *Using multiple channels (e.g., local radio, mothers' groups, CHWs, community committees, local government) to promote key messages.*

Assumptions for Element 1	*Where Element 1 is Crucial*	*How Element 1 differs from other community programs*
■ Facilities exist and are functional. ■ Communities have geographic and economic access to facilities. ■ Ideally, health workers are trained in IMCI systems, improvements are in place, and quality of care meets standards.	■ Facilities and services have been improved, but utilization of child health services is still less than expected. ■ CHWs are linked to health facilities. ■ MOH or other organization has limited experience with community work.	■ Linkages are made to implementation of IMCI in facilities. ■ Facilities increasingly are held accountable for quality of services they provide. ■ Community is involved in management and sustaining systems improvements. ■ Community has a role in the maintenance of service quality.

- *Developing methods for participatory community assessment and planning, such as the PRA methodology advocated by the MOH in Uganda.*

Further applied research is critical to guide better practices related to this element. Many CHWs or other community-based resource people who are mobilized to promote messages are often left alone for long periods of time without supportive mentoring or supervision. If they do not receive regular technical updates, their effectiveness will drop over time. Consistent messages about the key family practices are needed across multiple sectors. Many organizations still struggle with how to promote multiple behaviors effectively, how to maintain behavior change over time, and how to scale up these community-based interventions to regional and national levels.

Linkages with Other Health Sectors and Initiatives

The framework is meant to be inclusive and to help facilitate collaboration, dialogue, and linkage with other health sectors and initiatives implemented at the community level. Table 2 (see page 8) highlights some of these possible linkages.

Assumptions for Element 2	***Where Element 2 is Crucial***	***How Element 2 differs from other community programs***
■ Many children continue to receive treatment outside of health facilities, even though facilities may offer those services sought by the community.	■ Long distances and / or difficult terrain separate people from health facilities, especially during the rainy season. ■ Traditional healers and private providers are the major sources of care. ■ There is concern about unsafe treatment practices in the community setting.	■ Focus is on formal and non-formal private providers, not just CHWs. ■ Training courses for community-based workers are integrated rather than disease specific. ■ IMCI concepts and tools are adapted for use in the home and community (e.g., treatment of all conditions a child has, algorithms for making decisions).
Assumptions for Element 3	***Where Element 3 is Crucial***	***How Element 3 differs from other community programs***
■ Community input into the design and delivery of local communication and behavior change (CBC) strategies (when complemented by national or district CBC strategies) will have the greatest effect on influencing behavior change.	■ In all areas where promotion of the key family practices (preventive and curative) will result in improved child health through: – Enhanced physical growth and mental development – Prevention of disease – Appropriate home care – Appropriate care-seeking behavior.	■ More systematic approach to integrated promotion of different behaviors. ■ Better "support-a-vision" systems that combine supervision and empowerment. ■ Greater community input into the selection of behaviors to be promoted. ■ Link to IMCI implementation in facilities. ■ Introduction of innovative strategies such as Positive Deviance.

Principles of HH/C IMCI Operational Framework

After much discussion participants developed the following principles for implementation of HH/C IMCI.

- **HH/C IMCI can be implemented at national, district, and/or community levels, as appropriate.**
  Ideally, HH/C IMCI has the most value when implemented at all levels, but it is valuable at any level even when HH/C IMCI is not yet operational at the national level.
- **HH/C IMCI can be implemented by multiple actors or by a single organization.**
  If properly organized, collective groups can contribute the most toward an HH/C IMCI vision, but any organization (given adequate human and financial resources) can make a difference.
- **HH/C IMCI recognizes the importance of curative and preventive interventions in the community for reducing child mortality and morbidity.**
  HH/C IMCI places a high value on promoting an environment where children can thrive with minimal risk of disease and recover rapidly from illness.
- **HH/C IMCI can be implemented with or without IMCI Components 1 (Health Worker Skills) and 2 (Health System Supports).**
  All three IMCI components contribute to an effective life-saving strategy, but where necessary, HH/C IMCI can function independently and still make a major contribution to improved child health.
- **All three elements are requisite for HH/C IMCI (except element 1 if facilities are inaccessible).**
  The proposed elements are necessary to improve child health in the community. If public facilities do not exist in the community catchment area, however, advocacy for increased facilities is essential as a first step.
- **Phased introduction of promotion of key family practices is acceptable.**
  A communication and behavior change strategy should be constructed according to a seasonal calendar that matches local morbidity trends, and in a sequence that builds upon progress made and confidence gained at the individual, household, and community levels.
- **Phasing of introduction of the three elements is acceptable.**
  Prioritization for implementation of elements should be done based on assets and needs analyses at district and community levels.

Table 1. List of Key Family Practices adopted by WHO and UNICEF

[List presented at The International Workshop on Improving Children's Health and Nutrition in Communities, Durban, June 20–23 2000]

Key Community IMCI Family Practices

For physical growth and mental development

- Breastfeed infants exclusively for at least four months and, if possible, up to six months. (Mothers found to be HIV positive require counseling about possible alternatives to breastfeeding.)
- Starting at about six months of age, feed children freshly prepared energy- and nutrient-rich complementary foods, while continuing to breastfeed up to two years or longer.
- Ensure that children receive adequate amounts of micronutrients (vitamin A and iron, in particular), either in their diets or through supplementation.
- Promote mental and social development by responding to a child's needs for care through talking, playing, and providing a stimulating environment.

For disease prevention

- Take children as scheduled to complete the full course of immunizations (BCG, DPT, OPV, and measles) before their first birthdays.
- Dispose of feces, including children's feces, safely; wash hands after defecation, before preparing meals, and before feeding children.
- Protect children in malaria-endemic areas by ensuring that they sleep under insecticide-treated bednets.
- Adopt and sustain appropriate behavior regarding prevention and care for HIV/AIDS affected people, including orphans.

For appropriate home care

- Continue to feed and offer more fluids, including breastmilk, to children when they are sick.
- Give sick children appropriate home treatment for infections.
- Take appropriate actions to prevent and manage child injuries and accidents.
- Prevent child abuse and neglect and take appropriate action when it has occurred.
- Ensure that men actively participate in providing childcare and are involved in the reproductive health of the family.

For seeking care

- Recognize when sick children need treatment outside the home and seek care from appropriate providers.
- Follow the health worker's advice about treatment, follow-up, and referral.
- Ensure that every pregnant woman has adequate antenatal care. This includes having at least four antenatal visits with an appropriate health care provider and receiving the recommended doses of the tetanus toxoid vaccination. The mother also needs support from her family and community in seeking care at the time of delivery and during the postpartum and lactation period.

Table 2: Linkages between the HH/C IMCI Implementation Framework and Other Health Initiatives

HH/C IMCI Framework	*Roll-Back Malaria*	*Nutrition*	*Immunization*	*Peri/Neonatal*	*HIV/AIDS*	*Early Childhood Development*
Multi-sectoral Platform	Collaboration with other sectors on ■ Production, packaging, sales, and distribution of rugs, nets, insecticides. ■ Limiting malaria transmission resulting from economic development, deforestation, irrigation).	■ Collaboration with other sectors working on agriculture production, food security, emergency feeding programs, income generation, etc.	■ Support for vaccination by other government ministries and the private sector.	■ Collaboration with various services / programs aimed at women/families/ children to improve awareness of neonatal health.	Collaboration with other ■ Sectors on HIV/AIDS programs including (awareness, behavior change and care), education, agriculture, churches, MED, food security. ■ NGOs/CBOs, self-help groups (youth/women). ■ Ministries of local government, labor, finance, information.	■ Development of comprehensive national ECD policies addressing the emotional, cognitive, social, and physical development of the young child through inter-sectoral collaboration. ■ Creation of a nationally defined and measured developmental check list.
Element 1: Improving partnerships between health facilities (and services) and the communities they serve	■ Collaboration between health services and communities on community-wide vector control. ■ Community input into decision-making on malaria control.	■ Collaboration between health services and communities on growth promotion, nutrition rehabilitation, micronutrient delivery.	■ Communities work with health facilities and outreach teams to ensure all children and women of reproductive age are fully immunized.	■ Collaboration between health services and communities to improve neonatal care in the community and promote referral of ill newborns to health facilities.	■ Collaboration with clinics, hospitals, and laboratories (if present) and outreach programs for awareness, testing, referral, condom distribution, and surveillance. ■ Community feedback into and co-management of HIV/AIDS programs.	■ Collaboration among health services, communities, and parents on monitoring developmental milestones. ■ Improve counseling & feedback by facility-based personnel on monitoring developmental milestones.
Element 2: Increasing appropriate and accessible care and information from community-based providers	■ Improved treatment of cases of malaria & promotion of malaria prevention by private providers, shopkeepers, and traditional healers.	■ Improved nutrition counseling by private providers. ■ Growth monitoring and nutrition education by CHWs.	■ Promotion and support of immunization by CHWs, TBAs, and private providers.	■ Improved essential newborn care by birth attendants. ■ Referral/treatment of sick newborns by CHWs and private providers.	■ Linkages with CHWs, TBAs, traditional healers, and private providers for awareness, referral for testing and treatment, home care counseling, condom distribution, and reduction in risk from unsafe injections.	■ Improved early care and development by primary caregivers (e.g., mothers) through caregiver education/program given through CHWs and other community workers.
Element 3: Integrated promotion of key family practices critical for child health and nutrition	■ Improved home management of malaria. ■ Promotion of Insecticide Treated Materials integrated with other behavior change activities.	■ Promotion of nutrition interventions and behaviors fully integrated with promotion of other key family practices.	■ Promotion of child and maternal vaccination integrated with promotion of other interventions / services (e.g., vitamin A).	■ Promotion of essential newborn care and appropriate care seeking behavior integrated with promotion of other key family practices.	■ Promotion of condom use, STI referral, improved partner testing and commitment to monogamy; identification and support of HIV affected households/ orphans. ■ Reduction in transmission risk from injections, blood transfusion.	■ Promotion of emotional, cognitive, social, and physical development of 0- to 5-year olds with focus on early stimulation and learning at home, integrated with promotion of other key family practices.